Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, January 29, 2025
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.

I.	Announcements	A. Siebert
II.	Substance Use Disorder (SUD)	J. Davis/G. Lindsey
III.	Recipient Rights	M. Strong
IV.	**QAPIP Effectiveness**	
	PIHP Crisis Access	
	a) Preadmission Review Process	D. West
	Quality Improvement	
	b) MDHHS Waiver & iSPA CAP Updates	D. Dobija
	c) First Quarter, FY2025 Case Record Self-Reviews	D. Dobija
	d) FY2024 Medicaid Claims Verification	D. Marshall/D. Stevens
	e) HSAG FY2024 Compliance Review	T. Greason
	f) CE/SE Updates	C. Spight-Mackey
V.	Adjournment	

Quality Operations Technical Assistance Workgroup Meeting Agenda
Wednesday, January 29, 2025
Via Zoom Link Platform
9:30 a.m. – 11:30 a.m.
Note Taker: DeJa Jackson

1) **Item: Announcements:**
   - The organization is now a fully certified CCBHC demonstration site, effective January 2025.
   - The certification expands member choices and broadens the scope of services available in the community.
   - Staff departure of Sinitra Applewhite from the Quality Improvement unit.

2) **Item: Substance Use Disorder (SUD) – G.Lindsey/ Judy Davis**
   Goal: Updates from SUD

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
No SUD updates (Tabled for February)		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback was provided.		
Action Items	**Assigned To**	**Deadline**
None required.		

3) Item: Recipient Rights – Mignon Strong
Goal: Updates from ORR

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Mignon Strong, Deputy Director of ORR shared the following ORR Updates: • Chad W. retired in December 2024 and Mignon will be handling Recipient Rights matters moving forward. *Remedial Action Requests*: • Respondents must ensure timely responses (within 5 days) to meet statutory requirements. • The CEO or Executive Director of each assigned provider must officially designate someone to receive recipient rights reports. *Death Reporting Concerns*: • Some inconsistencies are noted in the information requested when reporting deaths. • A standardized death report form should always be used when reporting a death. Also, additional questions may be asked based in the nature of the death and potential investigations.		
Provider Feedback	**Assigned To**	**Deadline**
Questions/Concerns: 1. Some of the ORR staff are asking for more information than other staff. 2. Is there a formal process for designating someone other than the CEO to receive remediation requests? Answers: 1. The standardized death report form should always be used. Additional questions may arise based on the circumstances of the death. 2. The CEO must send an email or letter designating a staff member. However, the CEO will still be copied on reports.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: PIHP Crisis Access

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Dan West, Director of Crisis Access, shared the following information with the workgroup, the PAR Dispatch departmental function. The Preadmission Review Process is created to develop a team of dedicated, driven, and motivated professionals to ensure timely, efficient and empathetic crisis services are delivered to our community. This team will go above and beyond for our members and community. With a commitment to continuous quality improvement, we will maintain a culture of clarity and understanding. We will continue to cultivate healthy, professional relationships and partnerships in the community based on our goal of high-level member care for members in crisis. *Expansion of Pre-Admission Review Process*: • A new PAR Dispatch Team has been introduced to centralize emergency department and childcare institute referrals. • This process improves efficiency and streamlines access to crisis services. *Statistics from November- December 2024* • Service level standards: 84% (above the state's 80% requirement) • Calls are now answered in 22 seconds on average. *Emergency Department Transfers:* • Some hospitals are transferring individuals without prior notification. Hospitals will be reminded that prior calls are required before transferring members to crisis stabilization units. Please review "PAR Dispatch Department Presentation, QOTAW 1.29.pptx" for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
Questions/Concerns: 1. Hospitals are dropping off members via rideshare services (Lyft/Uber) without prior notice. 2. Is the new Crisis unit operational 24/7? Answers: 1. This violates established procedures. Hospitals will be reminded of the proper process to prevent future occurrences. 2. Yes, the unit operates 24/7, 365 days a year.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Danielle Dobija, QI Administrator, provided the following updates: *MDHHS Waiver & iSPA CAP Updates* • Additional documentation is required by the state to complete the Corrective Action Plan. • 36 providers are currently submitting outstanding information. • The final evidence submission deadline to MDHHS is January 31, 2025. *First Quarter, FY2025 Case Record Self-Reviews* • Providers must complete 20 case record reviews and submit them by March 21, 2025. • New audit questions focus on reengagement attempts, closed cases, and utilization of case management services. Please see handout" Performance Monitoring 1.29.2025.pptx" for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
No additional provider feedback provided.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Dayna Stevens and Delisha Marshall, Clinical Specialist - Performance Monitor, shared the following information with the workgroup: *FY2024 Medicaid Claims Verification* Common Issues Identified in 2024 Reviews • Lack of valid Individual Plans of Service (IPOS): 28% of claims lacked valid documentation. • Direct Care staff not properly trained on the IPOS: 27% of review cases had training deficiencies. Recommendations: • Providers must ensure that all direct care staff are trained by a case manager or designated trainer. • Running training logs are no longer acceptable; each training session must be documented separately. Please see handout "FY2024_ClaimsData.Trends.pptx" for additional information.		
Provider Feedback	**Assigned To**	**Deadline**
Questions/Concerns: 1. Can Medicaid claim reviews be conducted quarterly instead of biannually to reduce administrative burden? 2. Suggests pulling claims earlier in the reporting period to give providers more time to submit documentation. Answers: 1. This would double the number of claims reviewed, making it more difficult to complete. Alternative solutions are being explored. 2. DWIHN will explore moving up claim pulls to ease the burden on providers.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: Quality Improvement
Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		

Tania Greason, QI Administrator, shared the following:
 	
HSAG (External Quality Review) FY2024 Compliance Review
• Final Score: 88% (increase from 77% the previous FY2022 year review).
• Corrective Action Plan is due January 29th, 2025 addressing issues identified in the following areas:
  ○ Availability of Services (94%)
  ○ Coverage and Authorization of Services (77%)
  ○ Member Rights and Member Information (82%)
• DWIHN received 100% compliance for the following areas:
  ○ Assurance of Adequate Capacity and Services
  ○ Coordination and Continuity of Care
• The next compliance review cycle for 2025 is currently underway with a review date scheduled for June 13th, 2025. Information will be provided to the workgroup for the CAP (FY2024) and the Review (FY2025) as it becomes available.		

Provider Feedback	**Assigned To**	**Deadline**
No Provider feedback.		
Action Items	**Assigned To**	**Deadline**
None required.		

4) Item: QAPIP Effectiveness
Goal: Quality Improvement

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ Quality ☐ Workforce
NCQA Standard(s)/Element #: QI ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Discussion		
Jasmine Strife, Registered Nurse- Performance Improvement, shared the following updates: *CE/SE Updates:* New Reporting Requirement for Falls: • All falls must now be documented and reported to MDHHS, not just falls resulting in injuries. • If a hospital visit occurs, discharge documentation, follow-up notes, and risk assessments must be submitted in the CE/SE module for reporting to MDHHS. • DWIHN has regulatory reporting requirements that must be followed per MDHHS. CRSP providers must adhere to requests for submission as outlined in the CE/SE reporting policy/procedure. Death Certificates: • Providers report difficulty obtaining death certificates from Wayne County. Follow-up efforts are in progress to address this issue.		
Provider Feedback	**Assigned To**	**Deadline**
Questions: 1. Are all falls required to be reported even if no medical attention was sought? 2. Mentioned challenges in obtaining death certificates from Wayne County, even with official DWIHN letters. Answers: 1. Falls that result in injuries are a reportable event for MDHHS and must be reported through the critical/sentinel event module in MHWIN 2. DWIHN will reach out to Wayne County Medical Examiner's Office to address the issue.		
Action Items	**Assigned To**	**Deadline**
None required.		

New Business Next Meeting: 02/26/25
Adjournment: 01/29/2025

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PAR Dispatch Department
QOTAW 1/29/25

Collective Vision

- **Create and develop a team of dedicated, driven, and motivated professionals to ensure timely, efficient and empathetic crisis services are delivered to our community. This team will go above and beyond for our members and community. With a commitment to continuous quality improvement, we will maintain a culture of clarity and understanding. We will continue to cultivate healthy, professional relationships and partnerships in the community based on our goal of high-level member care for members in crisis.**

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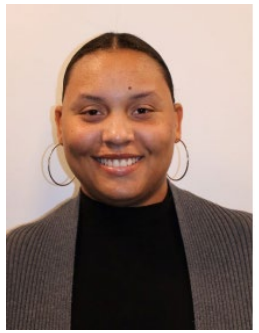
Par Dispatch Team



Darnisha Mackey

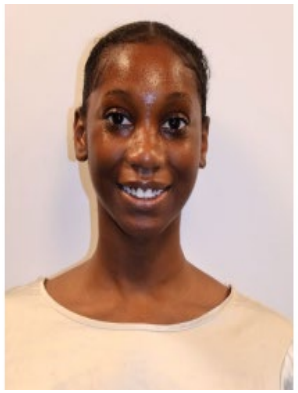
Natalia Harris

LaShawnta “Tae” Bushell

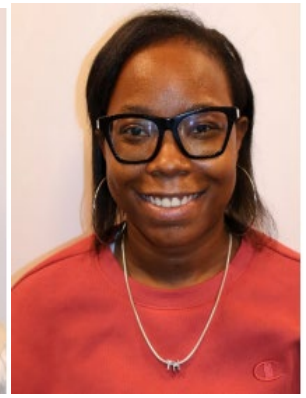
Alyssa Sutherland

Trevor Hohenthaner

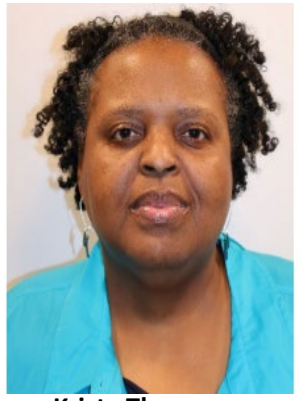
Trevion Henderson



Sockhna Diaw



Tanika Hutcherson

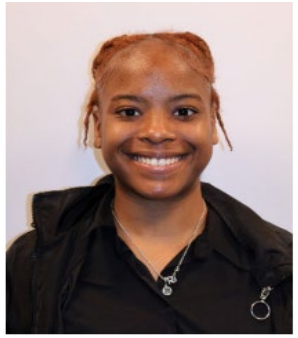


Krista Thompson

Jaylon Roberts

Alise Woods-Anthony

Ether Cranford



Rachel Arrington

Aiyana Harris

Felicia Wynn

Brieanna Hall

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Prep/Communication/Live Date

- Training and live walk-through
- Individual vs shift
- Team building
- COFR/Eligibility
- Process and procedure
- Shared documentation
- Live 11/1, 6am
- Communication and external training

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Barriers Overcome

- Essential components
- COFR/Eligibility
- Dispatch Module
- RFS/Dispatch timing
- Packets
- Direct contact numbers
- Genesys, missed calls, multiple departments, ring time
- Fax queue
- After call processing and special projects

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Trends/Heatmap November 2024

	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Shift	11/1/2024	11/2/2024	11/3/2024	11/4/2024	11/5/2024	11/6/2024	11/7/2024	11/8/2024	11/9/2024	11/10/2024	11/11/2024	11/12/2024	11/13/2024	11/14/2024	11/15/2024	11/16/2024	11/17/2024	11/18/2024	11/19/2024	11/20/2024	11/21/2024	11/22/2024	11/23/2024	11/24/2024	11/25/2024	11/26/2024	11/27/2024	11/28/2024	11/29/2024	11/30/202
6a-7a	1		1		1		3		1			1	1	[2]	2	[2]1			1	1			1	1		1	2			1
7a-8a	1	1	4		1	1				2			[1]	[1]4						1	[1]		1	1		1	1			
8a-9a	2	3	1		1	1	2	1		1	1		1	1	3	1			1						2	[2]2	2			
9a-10a	2	4	3	[1]2	3	1	8	[1]3	[1]2	1		1		[2]5	2	1		[1]1	[1]1	[1]2			2	[1]4		2	1		3	1
10a-11a	[1]	2		4		2	3	1	5	1	5	2	[1]1	1		4	1	[1]4	4	2	[2]3		[1]	3	4	2	1	2		2
11a-12p	[3]7	1	1	[1]2	[2]2	[1]6	[1]2	[1]4	4	2	[2]	[1]4	2	[2]	4	1		[1]2	5	2	[1]1	[2]4	1	5	6	4	[1]1	[1]4	3	2
12p-1p		4		5	[1]3	[2]5	[2]3	1		[1]1	6	[1]2	5	3	2	[1]2	2	1	[2]	4	[1]3	4	2	[1]	1	2	[1]3	3		1
1p-2p	[1]1	2	1	[1]7	4	1	1	[3]4	2	1	5	4	1	2	4		1	1	[2]10	[1]5	2	4	1	2	[2]9	7	[1]3	1	5	1
2p-3p	[2]2	2	4	4	[2]7	4	5		1	1	2	[2]2	4	5	[1]3	3	3	[1]3	[1]1	1	[1]2		4	3	3	[2]1	[1]5	1		[1]1
3p-4p	[1]3	3	1	3	[2]2	[1]	3	5			4	6	[2]2		[1]3	1	2	[2]3	4	[2]1	5	2	[2]2	1	[1]1	1	[1]2		1	3
4p-5p	2	3	4	[5]3	[1]	1	[1]1		3	3	[1]2	[2]2	[2]4	1	[2]3	1	2	5	[1]1	[1]1	5	3	6	2	[1]2		5	1	[1]3	
5p-6p	4	2	1	[2]1	[1]2	[2]	[4]2	3	[1]3	[1]3	3	[2]4	2	3	[2]1	2	2	[2]4	[1]3	6	4	[2]8	1		[1]5	2	4			2
6p-7p	1	2		2	[1]2	4	[2]1	4	[1]2	[1]2	1	4	1	1		[4]2	[1]4	[2]6	[1]3	4	[2]1	5	1		[2]4	2	1	3	1	
7p-8p	[1]4		4	3	[1]2			[2]6		[1]	[2]3	[1]2	[3]1	1	[1]2	[1]		[1]1	[1]3	[2]2	[2]	[1]	[2]	[1]	[3]	6	1	1	2	
8p-9p	[4]1	2		[2]2	[1]3	[3]1	[4]2	5				[4]2	1	4	[3]1	[1]2	2	[1]	[1]1	2		[1]1		[2]	3	1		1		
9p-10p	1	1	2	[4]1	[1]	2	[2]	[1]3	1		[1]1	[1]2	2	3	[1]2	1		2	[1]4	2	1	2	1		[1]2		1	1		[1]1
10p-11p		[1]1	[1]	[1]2	1	[1]	2	[1]	1				1	2	2	1		[1]3			1	[1]1	2		3	[3]	1			
11p-12a		1	1	1	[1]1	1	5	1	[1]	1			2	1								1	[1]1					2	1	[1]
12a-1a		[1]	[1]2			3	1	2	[2]2		[1]	[1]	1			[1]		1	2	1		3		[1]1	3	1		3	3	1
1a-2a	1		1	[1]1	[1]		2			1	1	2		[3]4	[1]	1	1	[1]1			[1]	1	[1]1		2	2	[1]	3	1	
2a-3a		1				1							1	1		1	1		1			1	[3]3		1	3				1
3a-4a	[1]	1				1	[1]		1	1			[1]	[1]							[1]1	3				1				
4a-5a		1	2									[1]1		1	[2]1					1	3	[1]	1	2		2	1	[1]		
5a-6a		1	2		1										[1]1	2				2	[1]	1	4	1	2			1	1	2

Requests for Service	
	9+
	7+
	5+
	3+
	2
	1
	0

The majority of requests for service were received between 9am and 7pm with most occurring in the beginning and end of the week. This will serve us to staff accordingly.

Raw Data November 2024

Shift	11/1/2024	11/2/2024	11/3/2024	11/4/2024	11/5/2024	11/6/2024	11/7/2024	11/8/2024	11/9/2024	11/10/2024	11/11/2024	11/12/2024	11/13/2024	11/14/2024	11/15/2024
Day Total	[5]14	17	11	[3]20	[3]15	[3]17	[3]22	[5]14	[1]14	[1]9	[2]17	[2]14	[2]11	[7]16	17
Aft Total	[8]18	15	13	[13]19	[10]18	[6]12	[13]14	[3]26	[2]10	[3]9	[4]16	[12]24	[7]17	18	[11]15
Mid Total	[1]1	[2]6	[2]8	[2]4	[2]3	[1]6	[1]10	[1]3	[3]4	3	[1]1	[2]3	[1]5	[4]9	[4]4

11/16/2024	11/17/2024	11/18/2024	11/19/2024	11/20/2024	11/21/2024	11/22/2024	11/23/2024	11/24/2024	11/25/2024	11/26/2024	11/27/2024	11/28/2024	11/29/2024	11/30/2024
[3]10	4	[3]9	[5]22	[2]17	[5]9	[2]12	[1]8	[2]16	[2]22	[2]21	[3]14	[1]10	11	8
[6]12	[1]15	[9]24	[7]20	[5]19	[5]18	[4]21	[4]15	[3]6	[9]20	[2]13	[2]19	8	[1]7	[2]7
[1]5	2	[1]5	3	4	[3]5	[2]11	[5]12	[1]4	11	[3]9	[1]2	[1]9	6	[1]4

	11/1/2024	11/2/2024	11/3/2024	11/4/2024	11/5/2024	11/6/2024	11/7/2024	11/8/2024	11/9/2024	11/10/2024	11/11/2024	11/12/2024	11/13/2024	11/14/2024	11/15/2024
Children	14	2	2	18	15	10	17	9	6	4	7	16	10	12	15
Adults	33	38	32	43	36	35	46	43	28	21	34	41	33	43	36

11/16/2024	11/17/2024	11/18/2024	11/19/2024	11/20/2024	11/21/2024	11/22/2024	11/23/2024	11/24/2024	11/25/2024	11/26/2024	11/27/2024	11/28/2024	11/29/2024	11/30/2024
10	1	13	12	7	13	8	10	6	11	7	6	2	1	3
27	21	38	45	40	32	44	35	26	53	43	35	27	24	19

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Feedback Received

- Positive interactions (Garden City, HF, Beaumont Eds)
- Efficiency in service (Children's, GCH)
- Demographics forms (Screening agencies)
- Multiple requests (COPE, 2-3 requests per clinician)
- Initial dispatch interaction (Trevion, Trevor, Alyssa)

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Data Analysis (11/1/24-12/31/14)

Metric	11/1/24-12/31/24
Calls	3,177
Percentage Answered Within 30 seconds	92%
Average Speed of Answer	22 seconds
Abandonment rate (5%)	7%
Service Level (80%)	84%

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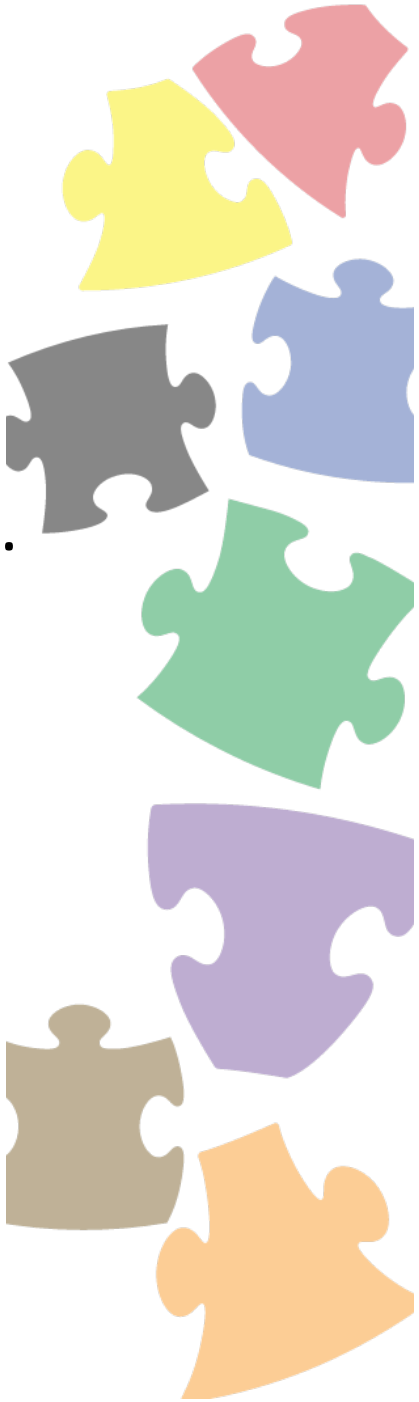
Quality Monitoring

- Ongoing 1:1/shift monitoring
- Teams chat, teamwork
- Chain of command
- Areas to re-train
- Consistent access to quality improvement
- Call reviews

Initial Goals

- Improve service level (85%+).
- Improve eligibility/COFR determination (COFR Log monitoring).
- Cultivate and maintain professional community relationships (Survey).
- Improve coordination of ACT PAR dispatch.



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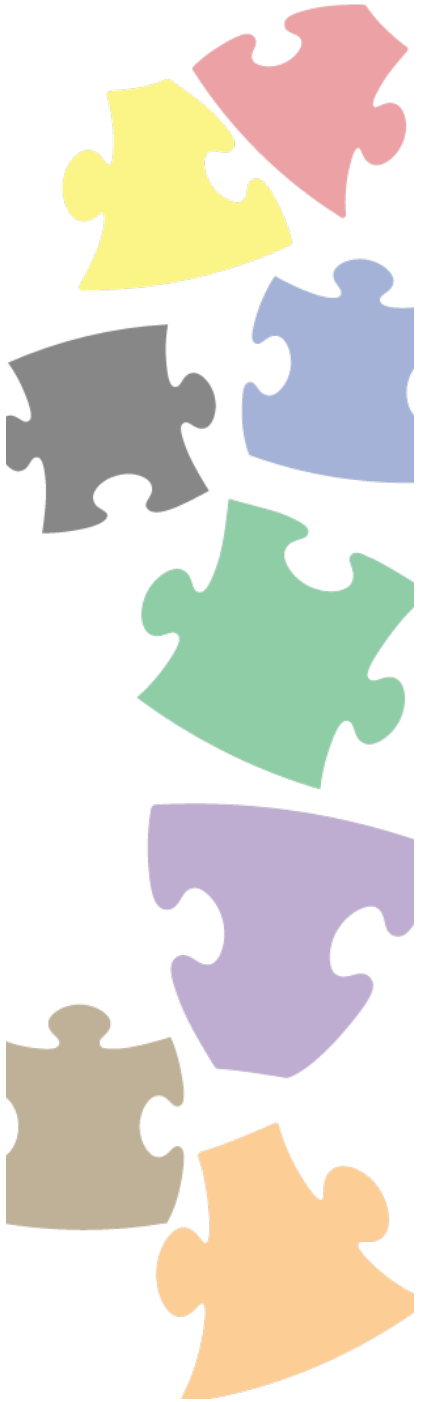
Questions



1st Quarter Case Record Self-Reviews for FY2025

Use the audit tool in MH-WIHN labeled:

FY2025 Quarter 1 Case Record Review

FY2025 Quarter 1 Case Record Review - Combined

20 assigned case records

Completion date for the review is **Friday, March 21, 2025**.

1st Quarter Case Record Self-Reviews for FY2025

For non-DWIHN assigned case record reviews, use the following:

FY2025 Provider Self-Monitoring Case Record Tool- NOT FOR USE WITH DWIHN QUARTERLY REVIEWS

Combined FY2025 Provider Self-Monitoring Case Record Tool- NOT FOR USE WITH DWIHN QUARTERLY REVIEWS

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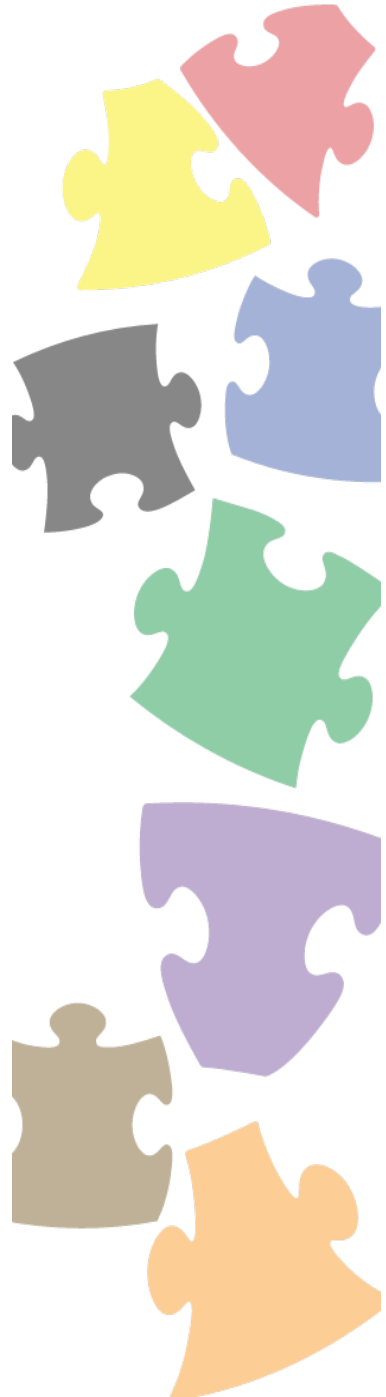
FY2025 Case Record Tool Changes

Plan of Service and Documentation Requirements

Question #11 (**New**) For records lacking evidence of services being provided as specified in the IPOS, the record includes a documented rationale when services are not occurring as specified in the IPOS.

Question #15 (**New**) For members that have not been seen or have not had contact with the CRSP Provider for 60 calendar days, there is evidence of re-engagements attempts in the record.

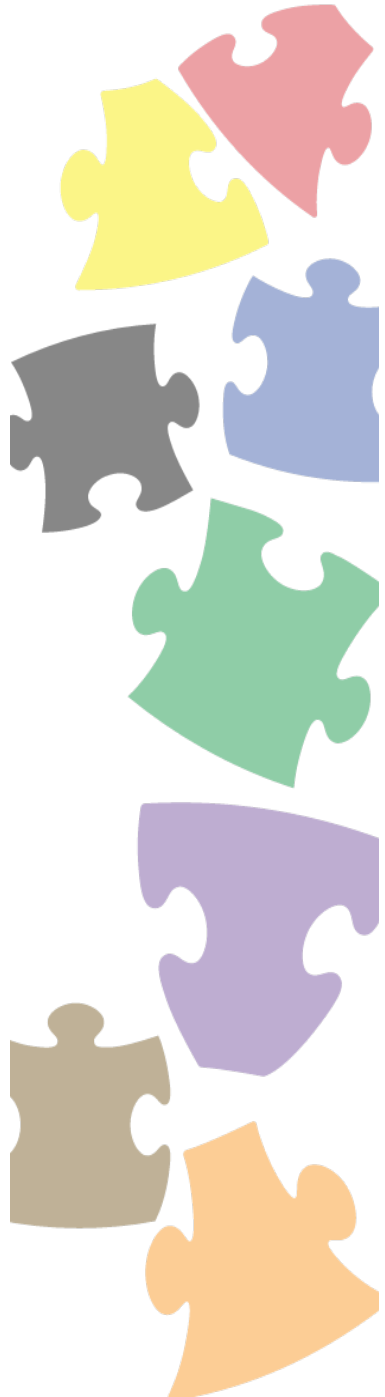


FY2025 Case Record Tool Changes

Plan of Service and Documentation Requirements

Question #16 (**New**) For Closed Cases, there is evidence of a CRSP Discharge Record completed within 14 calendar days from when the member was discharged from the CRSP.

Question #17 (**New**) For Closed Cases, a copy of the Discharge Summary is uploaded to MHWIN within 14 calendar days from when the member was discharged from the CRSP.



FY2025 Case Record Tool Changes

Targeted Case Management / Supports Coordination

Question#5 (**New**) For records lacking evidence of Case Management / Supports Coordination services being provided as specified in the IPOS, the record includes a documented rationale when services are not occurring as specified in the IPOS.

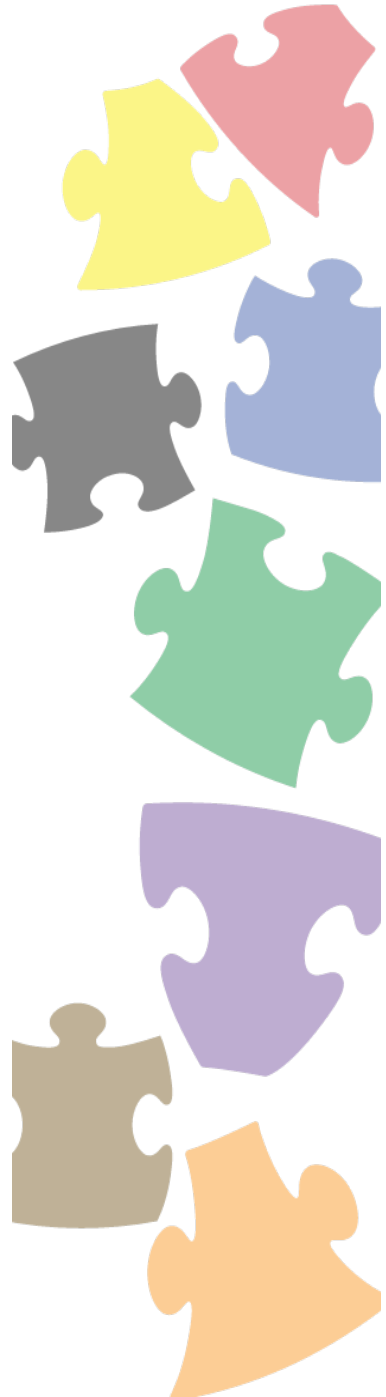
FY2025 Case Record Tool Changes

Section #12 for Wraparound was revised to

Intensive Care Coordination with Wraparound (ICCW) Fidelity Standards

Section #13 **Serious Emotional Disturbance Waiver (SEDW)**

Question #6 (**New**) There is evidence that the consumer has received at least one SEDW service per month in addition to Intensive Care Coordination with Wraparound (ICCW).



FY 2024 Medicaid Claim Verification Findings/Trends

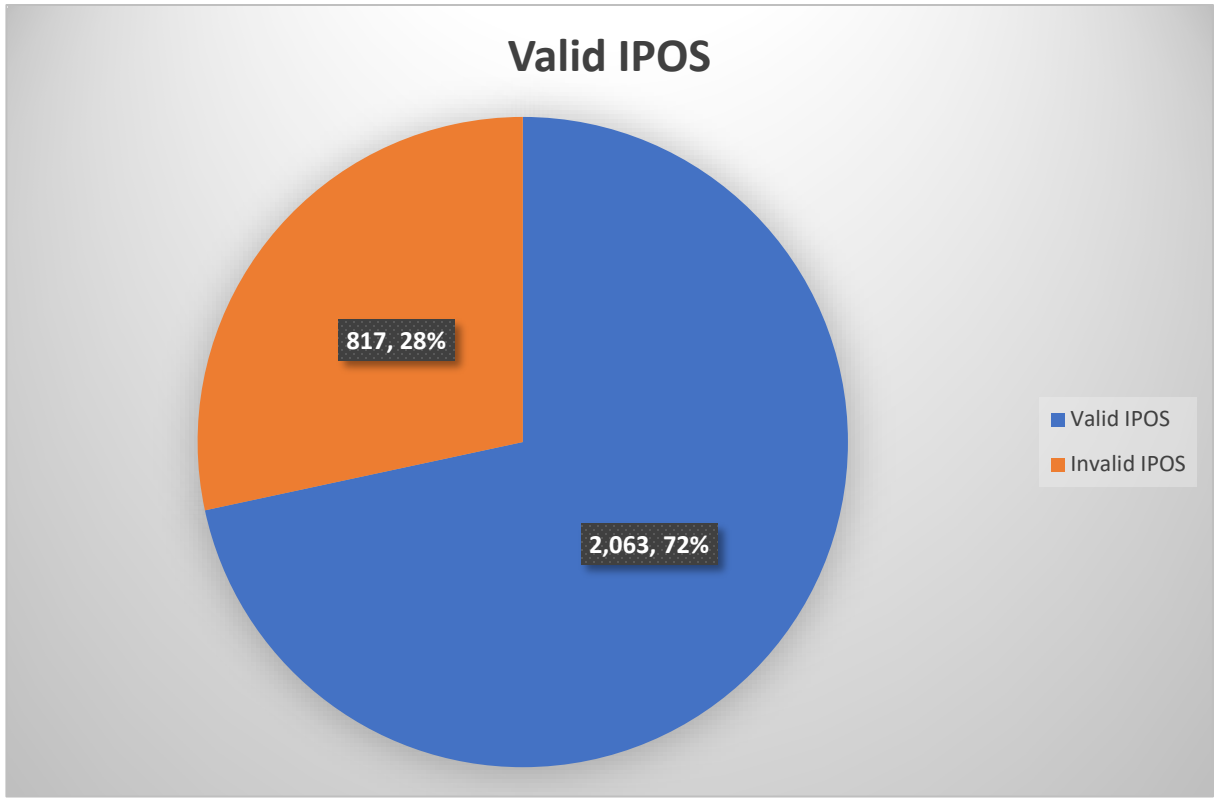
There were a total of 2,880 claims reviewed, the average score was 90%.

Of the standards reviewed, the following trends were noted: invalid IPOS' and direct care staff not being trained on the member's IPOS

Valid IPOS – *Evidence must include an IPOS that is signed and dated by the author and the legally responsible individual*

Standard: There is evidence of a valid IPOS at the time services are being delivered

Of the 2,880 claims reviewed, 2,063 or 72% had a valid IPOS, whereas 817 or 28% did not have evidence of valid IPOS



Staff trained on IPOS – *Evidence must include staff being trained by the SC/CM or someone who was trained by the SC/CM*

Standard: Staff delivering the service is fully qualified, including being trained on the member's IPOS.

Of the 2,880 claims reviewed, 2,034 were delivered by direct care staff who are required to be trained on the member's IPOS. Of those claims, 1,479 or 73% were supported with evidence of a valid IPOS training, whereas 555 or 27% of the claims did not have evidence, or valid evidence, of staff being trained on the IPOS.